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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L4-S1 fusion with coronal correction from an anterior-posterior approach for distraction of the L5-S1 space and for coronal correction as well as sagittal plane correction of the spine and stabilization with indirect decompression. Removal of the DCS

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Neurologist with over 34 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who was injured XX/XX/XX. The claimant was diagnosed with persistent postoperative low back and bilateral leg pain.

04/07/2014: Bilateral Hip (limited Pelvis) CT. **Impression:** Minimal arthrosis of the hips.

04/07/2014: Lumbar Spine CT. **Impression:** 1. Transitional anatomy at the lumbosacral junction. Lumbarization of SI is assumed for this report. 2. Right L/1 and L5 laminectomy. 3. Degenerative disc disease and spondylosis most pronounced at L5-S1, associated with mild right and moderate left neuroforaminal stenosis at this level. 4. Neurostimulator device.

07/07/2015: CT lumbar spine. **Impression:** The patient has a levoscoliosis centered at L3-L4 that appears to be acquired. There has been a previous right laminectomy at L5-S1. There is a slight grade 1, spondylolisthesis at L3-L4, accentuated in the prons position and reduced in the spine position. There is no significant compromise of the canal. However, there appears to be some left-sided impingement of the L5-S1 foramen and L5 nerve root.

07/07/2015: Lumbar myelogram. **Impression:** The patient has slight levoscoliosis centered at the L3 level. There are some degenerative changes at L5-S1, especially on the left side, that may cause some impingement of the nerve root.

07/24/2015: Letter. I am requesting a neurosurgical evaluation. The claimant has had chronic back and leg pain since her work injury on XX/XX/XX. She underwent a laminectomy in 2006 which partially reduced her pain. She subsequently had a spinal cord stimulator placed for persistent radicular pain. The stimulator provided her substantial relief for several years. She was able to return to school and has just recently completed her degree. Over the last year she has developed worsening pain in both legs, but especially the usual right leg pain in an L5 distribution. She has failed to improve injections. A neurosurgical consult was completed who ordered a CT myelogram. The myelogram shows compromise of the L5 nerves bilaterally. This represent worsening of her chronic condition caused by the injury. She has failed several attempts to control the X and I believe she has be helped by surgery.

07/31/2015: Office visit. **HPI:** She claimant has a history of multiple spine surgeries including discectomy and laminectomy. She most recently had a spine cord stimulator placed which really was not helping her much. Her symptoms are getting worse. She initially had right lumbar radiculopathy but now she has left lumbar radiculopathy. She has steadily increasing back pain and increased in her narcotic pain management. She declined this and is exploring other options with regards to treatment of her back pain which stems from an on the job injury XXXX. **Medications:** Adderall 15mg, Ibuprofen 800mg, Keppra 250mg, Lidoderm 700mg patch, Lyrica 75mg, Lyrica 300mg, Morphine 30mg, Prilosec 20mg, Prozac 20mg. **Review of Studies:** Reviewed a myelogram which was recently done. This shows significant disc height collapse at what I am calling L5-S1. She has transitional lumbosacral anatomy. She has L4-5 facet arthropathy from a coronal deformity. She has hip height discrepancy on plain x-rays and a fractional lumbosacral curve from L4-S1 that is mild.

10/02/2015: UR. Rationale for denial: The claimant is a female with a history of multiple low back injuries. There is no objective occasion of instability, symptoms spinal stenosis and there is no verifiable radiculopathy noted on electrodiagnostic testing. There are a number of previous surgeries. There is no noted pseudo arthrosis and there is no unstable fracture or evidence of a spinal cord injury. Therefore, when noting that there are ongoing complaints of low back pain, noting the multiple surgical interventions, tempered by the current imaging data both CT scan and myelogram, there is no clinical basis presented to support the need for a fusion surgery. As such, the request is recommended for non-certification.

10/23/2015: Office visit. Claimant was seen for follow up. I have looked at her CT scan and she actually has six lumbar vertebrae with a sacralized L6-S1 but she does have transverse processes in the five levels above this. What I was calling the L5-S1 disc previously is really an L5-L6 disc with significant disc collapse. At the level above, on AP imaging, she has a little bit of a lateral offset.

11/03/2015: UR. Rationale for denial: Evidence based medicine recommends this procedure as an option for the following conditions with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment, X-rays demonstrating spinal instability and or myelogram, CT-myelogram or MRI demonstrating nerve root impingement correlated with symptoms and exam findings. The spinal fusion to be performed at one or two levels and psychosocial screen with confounding issues addressed. In this case, the examination findings do not indicate a loss of muscle strength or sensation correlation with the surgical levels. Furthermore, there is no documentation regarding a psychosocial screen with confounding issues addressed. As such, the request for an anterior-posterior approach for a distraction of the L5-S1 space and for coronal correction as well as sagittal plane correction of the spine and stabilization with indirect decompression and removal of the DCS is non-certified. Therefore, the request for L4-S1 fusion with coronal plane correction from an anterior posterior approach for distraction of the L5-S1 space and for coronal correction as well as sagittal plane correction of the spine and stabilization with indirect decompression. Removal of the DSC is neither medically necessary or appropriate.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous determination has been upheld. The claimant has a failed back syndrome characterized by chronic back and leg pain following multiple surgical interventions pre-existing to her on the job injury. That being the case, there is no guarantee that additional surgery will make her better. The indications given for surgery are

primarily based on pain, and radiologist findings rather than clinical findings such as weakness, bowel or bladder functions that may be measurably improved. In my opinion, removal of the DSC is neither medically necessary or appropriate. Therefore, the request for L4-S1 fusion with coronal correction from an anterior-posterior approach for distraction of the L5-S1 space and for coronal correction as well as sagittal plane correction of the spine and stabilization with indirect decompression. Removal of the DCS is non-certified.

ODG Guidelines:

Patient Selection Criteria for Lumbar Spinal Fusion:

(A) *Recommended* as an option for the following conditions with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated e.g. acute traumatic unstable fracture, dislocation, spinal cord injury) subject to criteria below:

(1) Spondylolisthesis (isthmic or degenerative) with at least one of these:
  (a) instability, and/or
  (b) symptomatic radiculopathy, and/or
  (c) symptomatic spinal stenosis;
(2) Disc herniation with symptomatic radiculopathy undergoing a third decompression at the same level;
(3) Revision of pseudoarthrosis (single revision attempt);
(4) Unstable fracture;
(5) Dislocation;
(6) Acute spinal cord injury (SCI) with post-traumatic instability;
(7) Spinal infections with resultant instability;
(8) Scoliosis with progressive pain, cardiopulmonary or neurologic symptoms, and structural deformity;
(9) Scheuermann's kyphosis;
(10) Tumors.

(B) *Not recommended* in workers' compensation patients for the following conditions:

(1) Degenerative disc disease (DDD);
(2) Disc herniation;
(3) Spinal stenosis without degenerative spondylolisthesis or instability;
(4) Nonspecific low back pain.

(C) *Instability criteria:* Segmental Instability (objectively demonstrable) - Excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 15 degrees L1-2 through L3-4, 20 degrees L4-5, 25 degrees L5-S1. Spinal instability criteria includes lumbar inter-segmental translational movement of more than 4.5 mm. (Andersson, 2000) (Luers, 2007) (Rondinelli, 2008)

(D) After failure of two discectomies on the same disc [*(A)(2) above*], fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.)

(E) Revision Surgery for failed previous fusion at the same disc level [*(A)(3) above*] if there are ongoing symptoms and functional limitations that have not responded to non-operative care; there is imaging confirmation of pseudoarthrosis and/or hardware breakage/malposition; and significant functional gains are reasonably expected. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. Workers compensation and opioid use may be associated with failure to achieve minimum clinically important difference after revision for pseudoarthrosis (Djurasovic, 2011) There is low probability of significant clinical improvement from a second revision at the same fusion level(s), and therefore multiple revision surgeries at the same level(s) are not supported.

(F) *Pre-operative clinical surgical indications* for spinal fusion should include all of the following:

(1) All physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts including skilled therapy visits, and performance of home exercise program during

and after formal therapy. Physical medicine and manual therapy interventions should include cognitive behavioral advice (e.g. ordinary activities are not harmful to the back, patients should remain active, etc.);

(2) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or MRI demonstrating nerve root impingement correlated with symptoms and exam findings;

(3) Spine fusion to be performed at one or two levels;

(4) Psychosocial screen with confounding issues addressed; the evaluating mental health professional should document the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery;

(5) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing; (Colorado, 2001) (BlueCross BlueShield, 2002)

(6) There should be documentation that the surgeon has discussed potential alternatives, benefits and risks of fusion with the patient;

(7) For average hospital LOS after criteria are met, see Hospital length of stay (LOS).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**